U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 August 2007

Case No. 2004-BLA-6696

In the Matter of:
E.K.,[1]
Claimant,

v.

ELKHORN JELLICO COAL CO. INC.,
Employer,
and
LIBERTY MUTUAL INSURANCE GROUP,
Carrier,
and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
Ron Carson (Lay Representative),
On behalf of Claimant

Francesca Maggard, Esq.,
On Behalf of Employer/Carrier

BEFORE: Thomas F. Phalen, Jr.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

[1] Effective August 1, 1006, the Department of Labor directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site and to insert initials of such claimant/parties in the place of those proper names. In support of this policy change, DOL has adopted a rule change to 20 C.F.R. Section 725.477, eliminating a requirement that the names of the parties be included in decisions. Further, to avoid unwanted publicity of those claimants on the web, the Department has installed software that prevents entry of the claimant's full name on final decisions and related orders. This change contravenes the plain language of 5 U.S.C. 552(a)(2) (which requires the internet publication), where it states that "in ***each case*** the justification for the deletion [of identification] shall be explained fully in writing." (*emphasis added*). The language of this statute clearly prohibits a "catch all" requirement from the OALJ that identities be withheld. Even if §725.477(b) gives leeway for the OALJ to no longer publish the names of Claimants – 5 U.S.C. 552(a)(2) clearly requires that the deletion of names be made on a case by case basis.

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On August 18, 2004, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 41).[3] A formal hearing on this matter was conducted on July 27, 2006 in Hazard, Kentucky, by the undersigned Administrative Law Judge. (Tr. 1). All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[4]

The issues in this case are:

1. Whether this claim was timely filed;

2. Whether Claimant has pneumoconiosis as defined by the Act;

3. Whether Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether Claimant is totally disabled;

I also strongly object to this policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank*, 951 F. 2d 320 (11th Cir. 1992) and those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). This change in policy rebukes the long standing legal requirement that a party's name be anonymous only in "*exceptional cases*." *See Doe v. Stegall*, 653 F.2d 180, 185 (5th Cir. 1981), *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993), *and Frank* 951 F.2d at 323 (noting that party anonymity should be rarely granted)(*emphasis added*). As the Eleventh Circuited noted, "[t]he ultimate test for permitting a plaintiff to proceed anonymously is whether the plaintiff has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings." *Frank*, 951 F.2d at 323.

Finally, I strongly object to the specific direction by the DOL that Administrative Law Judges have a "mind-set" to use the complainant/parties' initials if the document will appear on the DOL's website, for the reason, *inter alia*, that this is not a mere procedural change, but is a "substantive" procedural change, reflecting centuries of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge's decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial "mind-set" constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[3] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[4] At the hearing the Employer stipulated to 25.91 years of qualifying coal mine employment. (Tr. 10).

5. Whether Claimant's disability is due to pneumoconiosis;

6. Whether Claimant has two dependents for purpose of augmentation;

7. Whether the Claimant has established a material change in conditions per §725.309(c),(d); and

8. Other issues which will not be decided by the undersigned but are preserved for appeal. (Item 18(b)).

(DX 41; Tr. 10-11).[5]

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

E.K. ("Claimant") was born on September 10, 1939 and was sixty-six years old at the hearing. (DX 3; Tr. 13). In terms of education, Claimant completed the sixth grade. (DX 3). In July of 1961, Claimant married E.D., and they remained married at the time of the hearing. (DX 3; Tr. 27). They have one child together, L.K. ("Child") who was born on May 12, 1967. (DX 3). According to Claimant, Child remains at home because she is disabled because of her "nerves."

Claimant stated that he worked for Elkhorn Jellico Coal Company ("Employer") as a foreman for nearly twenty-six years. (DX 3; Tr. 13). His employment ended in December of 1986 due to experiencing shortness of breath. (DX 3; Tr. 17). He last worked as a foreman, which required him to pick rock, shovel rock and coal, lift ties, drop cars, drop loads, and run a loader while overseeing the work of others. (Tr. 13-14; 16). The weight of lifting ties could get up to 300 pounds and take two men. (Tr. 14). Claimant constantly wore a mining belt weighing ten to fifteen pounds. (Tr. 15). At times, the mine was so dusty that he would have trouble seeing right in front of him. (Tr. 17). While in the mine, Claimant did not wear a dust mask. (Tr. 17).

Claimant testified that he was first told he was totally disabled by black lung in 1987 by whom he thought was Dr. Bethencourt.[6] (Tr. 24-25). He stated while he was not sure if it was this physician, he did in fact have the documents at home showing his black lung diagnosis. (Tr.

[5] While Employer had not initially marked 18(B) on DX 41 – Employer stated she wished it to be marked at the hearing. (Tr. 11). Employer also withdrew the issue of length of employment – stipulating to 25.91 years of coal mine employment. (Tr. 10).

[6] Claimant seemed unsure if this was in fact the doctor who first told him he was totally disabled by pneumoconiosis. (Tr. 24-26).

25). He says he left the mines because of his breathing problems, and for the past four years has been on 2.5 liters per day of oxygen, as well using the machine at night. (Tr. 26). Claimant also testified that he lives at home with his wife and daughter, the latter being disabled due to a nervous problem.[7] (Tr. 27).

Procedural History[8]

Claimant filed two claims – the first filed in 1988 – both of which were denied. (DX 1). The third claim filed in November of 1996 was deemed abandoned and denied by the Director on December 12, 1996. (DX 1). Claimant filed a subsequent claim which was denied on June 8, 1998 by the Director. Claimant appealed, and the administrative law judge denied benefits on March 23, 2001. (DX 1-26). From there, Claimant appealed to the Benefits Review Board, where the findings of the administrative law judge were affirmed. (DX 1-19).[9]

Claimant filed the instant claim for benefits on March 13, 2003. (DX 3). The Director issued a proposed decision and order awarding benefits on May 3, 2004. (DX 34). Employer timely appealed requesting formal hearing. (DX 37). The matter was transferred to this office on August 18, 2004. (DX 41).

Length of Coal Mine Employment

Claimant stated on his application that he engaged in coal mine employment for 28 years. (DX 3). The Director determined that Claimant established 25.91 years of coal mine employment. (DX 34). Employer stipulated to this determination at the hearing. (Tr. 10). I find this stipulation to be supported by the record and the findings of previous adjudicators. Therefore, I hold Claimant worked 25.91 years in or around the coal mines.

Claimant's last coal mine employment was in the Commonwealth of Kentucky (DX 1, 3, 7). Therefore, the law of the Sixth Circuit is controlling.[10]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Elkhorn Jellico Coal Co. ("Employer") as the putative responsible operator due to the fact that it was the last company to employ Claimant for a full year. (DX 34). Employer does not contest this issue and it is supported by the evidence of record. (Tr. 10; DX 7; DX 41). Therefore, I find Elkhorn Jellico Coal Co. is correctly identified as the responsible operator.

[7] Claimant stated that she is currently on "SSI," but was not disabled before the age of 18. (Tr. 27-28).
[8] I note the Director's file contains three books, the pages of which are not in chronological order.
[9] Up to this point, it appears Claimant failed to establish any element of entitlement.
[10] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

Dependency

Claimant asserted he has two dependents. He testified that he still lives at home with his wife. (Tr. 27). In this regard, I find the evidence sufficient to establish that she is a dependent for purposes of augmentation. However, Claimant also asserted that his daughter, who was born in 1967, is also living at home and is dependent because she is disabled by nerves and receives "SSI." (Tr. 27). Claimant did not think she was disabled before the age of 18. Here, there is no evidence, outside of Claimant's testimony that his daughter qualifies as a dependent under § 725.209(a). I do not find this sufficient to meet the burden to establish dependency. As such, I find that Claimant has only one dependent for purposes of augmentation.

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001). In addition, the court stated:

> The three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of a miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. [Footnote omitted.] Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course, he may continue to pursue pending claims.

Id.

However, in a subsequent opinion, the Sixth Circuit adopted a position which states that when a doctor determines a miner is totally disabled due to pneumoconiosis, and a subsequent judicial finding holds that the claimant is not totally disabled due to pneumoconiosis, the medical determination must be a misdiagnosis and cannot "equate to a 'medical determination' under the statute." *Peabody Coal Co. v. Director, OWCP*, 48 Fed. Appx. 140 at 146 (6th Cir. Oct. 2, 2002)(unpub.). In summary, "if a miner's claim is ultimately rejected on the basis that he does not have the disease, this finding necessarily renders any prior medical opinion to the contrary invalid, and the miner is handed a clean slate for the statute of limitation purposes." *Id.*

In an unpublished opinion arising in the Sixth Circuit, *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.), the Benefits Review Board held that *Kirk*, 264 F.3d 602 is controlling and directed the administrative law judge in that case to "determine if [the physician] rendered a well-reasoned diagnosis of total disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.

In regard to this issue Employer's entire argument stated:

> [T]here is no doubt that the Claimant had previously been diagnosed with a totally disabling respiratory impairment due to coal dust exposure. He testified at the hearing that he was first diagnosed with a totally disabling respiratory impairment due to coal dust exposure in 1987. Dr. Bethencourt, his family physician, as well as doctors that examined him in conjunction with the state black lung claim.[11] Indeed, evidence contained in Director's Exhibit 1 indicates that he was diagnosed with a totally disabling impairment.

Employer's Brief *citations omitted*.

First, Claimant stated he *thought* it was Dr. Bethencourt who made such a finding in 1987, but he was not sure. (Tr. 24-25).[12] Second, it appears the reports from the state black lung are not contained within this claim. Therefore, there is no way for the undersigned to determine if they were well reasoned and well documented. Finally – Employer has pointed the undersigned to look at the evidence contained within Director's Exhibit 1 to support its assertion. Here, Director's Exhibit 1 consists of 941 pages. It is not the job of the administrative law judge to examine an entire record to discover if Employer's assertions are correct. Rather, the Employer is responsible to present specific evidence to *rebut* the presumption given to Claimant under § 725.308(c). As Employer has not pointed to a specific piece of evidence within the record which fulfills Employer's right to rebut the assertion that this claim was timely filed – I find Employer has not rebutted the presumption contained at § 725.308(c). Therefore, I find this claim timely filed.

NEWLY SUBMITTED MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be

[11] This incomplete sentence is the original writing of Employer – not the mistake of this judge.

[12] I would also like to note the record contains no medical reports from Dr. Bethencourt. Thus, it would be impossible for the undersigned to determine if his opinion was well reasoned and well documented.

admissible under Section 725.414(a)(2)(i) and (3)(i) or Section 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of Sections 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under Section 725.414. § 725.406(b).

Claimant selected Dr. Glen Baker to provide his Department of Labor sponsored complete pulmonary evaluation. (DX 12). Dr. Baker conducted the examination on May 5, 2003. (DX 13).[13] I admit Dr. Baker's report under Section 725.406(b).[14]

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 5). Claimant designated Dr. Alexander's reading of the April 29, 2002 x-ray (DX 16) and Dr. Aycoth's reading of the March 26, 2003 x ray (DX 16) as initial evidence. Claimant also designated Dr. Alexander's second reading of the April 29, 2002 x-ray (CX 3) as rehabilitative evidence. As rebuttal evidence, Claimant submitted Dr. Ahmed's reading of the May 9, 2003 x-ray (CX 1), and his reading of the May 5, 2003 x-ray. (CX 2). Claimant designated the PFT studies from Dr. Narayanan dated May 13, 2002[15] and April 30, 2003 as initial evidence. (DX 16). In terms of medical reports, Claimant designated Dr. Alam's medical reports dated January 23, 2004 and February 14, 2006 as initial evidence. (DX 16a; CX 4). Finally, Claimant designated treatment records from the St. Charles Health Clinic contained at DX 16. Claimant's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit Claimant's designated evidence in its Summary Form.

Employer completed a Black Lung Benefits Act Evidence Summary Form. (EX 7). As initial evidence, Employer designated Dr. Dahhan's reading of the May 9, 2003 x-ray (DX 15) and Dr. Wheeler's reading of a June 10, 2004 x-ray. (EX 5). As rebuttal evidence, Employer designated Dr. Wheeler's readings of x-rays dated April 29, 2002 (EX 4), March 26, 2003 (EX 6),[16] and May 5, 2003.[17] Under PFTs and ABGs, Employer submitted Dr. Dahhan's readings from a May 9, 2003 study (DX 15) and Dr. Fino's readings from a June 10, 2004 study (EX 5). Employer also submitted the medical reports of Dr. Dahhan (DX 15, EX 2) and Dr. Fino (EX 5) along with their depositions (EX 1, 3).

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[13] The exam consisted of a physical evaluation, x-ray, PFT, ABG, and medical report.

[14] The set of PFTs obtained on May 5, 2003 were invalidated by Dr. Burki due to suboptimal effort on May 25, 2003. (DX 13). Dr. Burki validated the follow up PFT dated June 6, 2003 on July 20, 2003. (DX 13). The latter PFT shall therefore be considered as part of the DOL sponsored complete pulmonary evaluation.

[15] The Summary Evidence form indicates this test took place on May 12, 2002 – but it is in fact dated May 13, 2002. (DX 16).

[16] Employer designated this reading as "EX 7" on its summary form, but designated it as "EX 6" at the hearing.

[17] Employer noted this x-ray was contained at "EX 1." (EX 7). At the hearing, no such x-ray reading was read into the record for admission, and EX 1 was identified as a deposition of Dr. Dahhan. (Tr. 8-9). However, an x-ray reading of the exact same dates as indicated in Employer's summary evidence form was conducted by Dr. Wheeler and is located at DX 17. I shall therefore consider this x-ray as Employer's rebuttal to the May 5, 2003 x-ray as indicated on its summary evidence form.

As Employer's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3), it is admitted for consideration in this claim.

X-RAYS

Exhibit	Date of X-Ray	Date of Reading	Physician/Qualification	Film Quality	Interpretation
DX 16	4/29/2002	7/11/2002	Dr. Alexander, B-Reader,[18] BCR[19]	2	1/1pp
CX 3	4/29/2002	9/24/2005	Dr. Alexander	2	1/1pp[20]
EX 4	4/29/2002	6/08/2004	Dr. Wheeler, B-Reader, BCR	3	Negative
DX 16	3/26/2003	9/17/2003	Dr. Aycoth, B-Reader	1	2/2pq
EX 6	3/26/2003	5/04/2004	Dr. Wheeler	3	Negative
DX 13	5/05/2003	5/05/2003	Dr. Baker, B-Reader	2	0/1pp
CX 2	5/05/2003	2/16/2004	Dr. Ahmed, B-Reader, BCR	2	1/0sp
DX 14	5/05/2003	5/19/2003	Dr. Burnett, B-Reader, BCR	1	Quality Only Reading
CX 1	5/09/2003	2/16/2004	Dr. Ahmed	2	1/0sp
DX 15	5/09/2003	5/09/2003	Dr. Dahhan, B-Reader	1	Negative
DX 17	5/09/2003	2/29/2004	Dr. Wheeler	2	Negative

PULMONARY FUNCTION TESTS

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height[21]	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results	Comments
DX 16	Good/	62/65	1.61	2.74		59	No	
5/13/2002	Good/Yes							

[18] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

[19] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[20] In his rehabilitative report, Dr. Alexander also rebuts Dr. Wheeler's reading of this x-ray dated June 8, 2004 where he notes it appears Dr. Wheeler read a copy of the x-ray – which is a dark copy – rather than the original, and in his opinion – is unreadable.

[21] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). As the three reports show varying heights from 64.5-66.1 inches, I will use the most common finding and thus find the miner's height to be 65 inches.

DX 16	Good/	63/65	1.54	2.67	58	No	
4/30/2003	Good/Yes						
DX 15	Good/	63/66.1[22]	1.28	2.33	55	Yes	
5/09/2003	Good/Yes		1.50*	2.64*	57*	No*	
DX 13	Fair/	63/64.75	1.58	2.93	54	Yes	Question maximum effort on FVL.
6/06/2003	Good/Yes						
EX 5	Good/	64/64.5	1.10	2.21	50	Yes	
6/10/2004	Good/Yes		1.50*	2.96*	51*	Yes*	

* Indicates Post-Bronchodilator Values

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**	**Comments**
DX 13	5/05/2003	36.0	83.0	No	
DX 15	5/09/2003	37.2	79.0	No	
EX 5	6/10/2004	35.3	68.9	No	

Narrative Reports

Dr. Baker provided the Department sponsored pulmonary evaluation on May 5, 2003. (DX 13). Dr. Baker considered the following: an age of sixty-three; an employment history of twenty-six years, last working in 1986 (eight underground, and eighteen on the surface); a family history of high blood pressure, heart disease, diabetes, cancer, and stroke; a patient history of 10-15 years of attacks of wheezing, 10-15 years of chronic bronchitis, 10-15 of arthritis, and 10 years of high blood pressure; surgical history of gallbladder surgery 5-6 years ago and hospitalization for breathing problems approximately 2 years ago; complaints of 10-15 years of sputum production, wheezing, dyspnea, cough, six years of orthopnea, and shortness of breath at night; a smoking history beginning 25-30 years ago at a pack a day in the past, and currently at half a pack a day; a physical examination revealing bilateral expiratory wheezing; objective testing including an x-ray (0/1), PFT (moderate obstructive defect – not reproducible); ABG (within normal limits) and an EKG. Based on the above, Dr. Baker diagnoses COPD with moderate obstructive defect (based on the non-reproducible PFT) and chronic bronchitis based on a history of cough, sputum production, and wheezing. Dr. Baker opined that these conditions were the result of both cigarette smoking and coal dust exposure and resulted in a moderate disability.

Dr. Abdul Dahhan, who is board certified in internal and pulmonary medicine, as well as a B-Reader, examined Claimant on May 9, 2003. (DX 15). Dr. Dahhan considered the following: an age of sixty-three years; an employment history of twenty-six years, ending in 1987 (ten years underground operating a scoop, shuttle car, continuous miner and bolt machine –

[22] Dr. Dahhan indicated Claimant's height to be 168cm. I take judicial notice that this equates to 66.1 inches.

the rest outside on the tipple); a smoking history of thirty years, with a pack per day until eight years ago when Claimant cut down to half a pack days; personal history of hypertension; current medications of Calan SR 240-mg daily, Theophylline tables twice per day, Combivent inhaler four times per day, nebulizer therapy as needed, and oxygen at night; physical symptoms of daily cough with productive clear sputum, but no hemoptysis, frequent wheeze, and dyspnea on exertion (such as a flight of stairs); physical examination revealing increase AP diameter with hyper resonance to percussion, and auscultation revealing reduced air entry to both lungs with bilateral expiratory wheeze (no crepitation or pleural rubs were audible); objective testing including an x-ray (hyperinflated lungs – consistent with emphysema, but negative for pneumoconiosis), PFT, ABG (normal), and EKG. Based on the above, Dr. Dahhan concluded that Claimant has COPD with significant response to bronchodilator therapy, but there are insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis. From a physiological standpoint, Dr. Dahhan opines that Claimant does not retain the respiratory capacity to continue his previous coal mining work or a job of comparable physical demand. However, his pulmonary disability, in Dr. Dahhan's opinion, is the result of a twenty-five pack year of smoking with no evidence of a pulmonary impairment caused by, related to, contributed to, or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

Dr. Dahhan provided a "supplementary report" dated April 23, 2004. In proffering his opinion, Dr. Dahhan considered the following: a spirometry dated May 13, 2003 showing an FVC of 2.64 and an FEV1 of 1.56 with no bronchodilators; a spirometry dated April 30, 2003 showing an FVC of 2.67 and an FEV1 of 1.54 with no bronchodilators; letter by nurse Brooks dated October 20, 2003 stating that Claimant was seen in the respiratory clinic with shortness of breath; Dr. Baker's report contained at DX 13; spirometry dated June 6, 2003 showing FVC of 2.93 and an FEV1 showing 1.58; and Dr. Alam's letter dated January 23, 2004 contained at DX 16a. Based upon his review of this evidence, Dr. Dahhan opines that there are insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis based on the obstructive abnormalities on clinical examination of the chest as noted by Dr. Baker. In Dr. Dahhan's opinion, Claimant suffers from COPD with a mild respiratory impairment – based upon the PFTs and ABGs. This impairment, in his opinion, is the result of a lengthy smoking habit. Even though Claimant has cut back in smoking – it still is not able to reverse the disease process that has already developed in Claimant's lungs secondary to the many years of smoking. Finally, Dr. Dahhan opines Claimant's pulmonary impairment was not caused by, related to, or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

In his deposition given on September 24, 2004, Dr. Dahhan emphasized his findings contained within his two previous reports. (EX 1). He noted that the x-ray showed hyperinflated lungs – a finding consistent with emphysema. He again concluded that Claimant suffered from chronic bronchitis and emphysema resulting from a lengthy smoking habit. His finding of no coal dust induced pulmonary disease was based upon "the entire data including the clinical examination, the pulmonary function studies, before and after bronchodilators, and arterial blood gases and a chest x-ray."

Dr. Mahmood Alam, who is board certified in both pulmonary and critical care medicine, provided a medical report dated January 23, 2004. (DX 16a). Dr. Alam stated he had been treating Claimant for "over a period of one year" and continues to treat Claimant on a regular

basis. Dr. Alam considered the following: an age of sixty-four years; a prior history of tobacco abuse down to "now only smoking maybe one or two cigarettes a day," but he later stated Claimant has "completely quit smoking"; twenty-six years as a coal miner (working as a roof bolter and working in the coal temple); symptoms of severe shortness of breath when Claimant exerts himself, walk on a treadmill or walk fifty-yards on a flat surface[23]; two year history of persistent cough with sputum production, mostly in the morning; a pulmonary evaluation revealing "a chest x-ray which showed bil[ateral] interstitial changes compatible with at least stage one of coal workers' pneumoconiosis by ILO classification," an oxygen saturation above 90%, an FEV1 at 66% of predicted with positive bronchodilator response, and a normal ABG with no hypoxemia. Dr. Alam stated it is reasonable to conclude that Claimant's symptoms are associated with coal dust exposure, based upon a positive x-ray, a twenty-six year coal mine employment history, an FEV1 of 66% predicted, and chronic pulmonary symptoms.[24] He concluded by stating "we are pretty confident to say in that respect that the symptoms are more related to his coal dust exposure with chronic bronchitis."

Dr. Alam provided a second medical report dated February 14, 2006. (CX 4). He stated Claimant has a history of coal workers' pneumoconiosis and chronic bronchitis, both resulting from exposure to coal dust. He cited a chest x-ray showing "significant emphysema bilaterally with nodular densities" and an FEV1 with severe airflow obstruction at 36%. Dr. Alam stated that Claimant's worsening dyspnea caused the need for cardiac evaluation, which resulted in multiple stents being placed in his heart. From a pulmonary perspective, Dr. Alam opined Claimant is totally disabled from returning to his former coal mine work as he is both steroid and oxygen dependent. This is to blame on over twenty-six years of coal dust exposure. Dr. Alam lists Claimant's current medication as: oral prednisone, inhaled bronchodilators, Theophylline, nebulizer treatment, prn antibiotics, and oxygen. He noted Claimant has not smoked in the last six months, since the stents were placed in his heart. Because Claimant's condition continues to worsen after he quit smoking six months ago, Dr. Alam opines that pneumoconiosis is likely causing his pulmonary impairment.

Dr. Fino, who is board certified in internal and pulmonary medicine and a B-reader, conducted a physical examination on June 10, 2004 and provided a report. (EX 5). In additional to his own medical evidence and physical examination, Dr. Fino also considered the following: a PFT dated May 13, 2002; chest x-ray reading dated March 26, 2003; PFT dated April 30, 2003; Dr. Baker's examination, including all objective testing, dated May 5, 2003; Dr. Dahhan's examination, including all objective testing, dated May 9, 2003; PFT dated June 6, 2003; Narrative Report from St. Charles Community Health Clinic dated October 20, 2003; and a letter from Dr. Alam dated January 23, 2004. Upon physical examination, Dr. Fino noted a sixty-four year old male with a coal mine employment history of twenty-six years, ending in 1986, with eight years underground and eighteen years above ground. Dr. Fino noted Claimant last worked on the coal tipple – dropping railroad cars and also served as a foreman – which required him to perform heavy labor such as shoveling and picking rock. Dr. Fino noted that Claimant had a thirty-pack year smoking history, beginning in 1974 with recently cutting down to half a pack days. In terms of symptoms, Dr. Fino noted Claimant complained of shortness of breath for

[23] Dr. Alam states pulmonary symptoms are "mostly exertional pertaining to shortness of breath …with no clear precipitating factor."

[24] Dr. Alam was also able to rule out TB and fungal infection of the lungs through a bronchoareolar lavage.

approximately twenty years, which continues to get worse. Walking on a flat level, ascending one flight of stairs, or lifting causes Claimant to become dyspneic. Along with chest pain, Claimant also stated he has a daily cough with mucus production, but no wheezing. Dr. Fino listed Claimant's current medications and past medical history, including a frequent history of colds – but noted the absence of emphysema, asthma, bronchitis, or bronchiectasis in Claimant's history. The physical examination of the lungs revealed decreased breath sounds with diffuse wheezes bilaterally. The objective testing Dr. Fino conducted consisted of the following: x-ray (0/0), PFT (severe obstructive ventilatory defect with over a 12% improvement after bronchodilators), ABG (mild resting hypoxemia). From all of the above, Dr. Fino diagnosed Claimant with a moderate airway obstruction consistent with COPD secondary to reversible chronic obstructive bronchitis and emphysema. Dr. Fino based his opinion on negative radiographic images, among other things. He acknowledged there are two significant risk factors which could cause Claimant's current condition: smoking and coal dust exposure. In pointing to studies from NIOSH regarding the interpretation of PFT studies to determine if the etiology of the impairment is coal dust or cigarette smoke, Dr. Fino noted that the improvement following bronchodilators was consistent with a smoking-related condition, and that had coal dust been a factor, the impairment would be much more severe. Dr. Fino also pointed to the PFT and how it has decreased over time which showed "that his progressive decline in FEV1 over the years is related to cigarette smoking and that is the cause of this man's disability." Concerning disability, Dr. Fino concluded Claimant was totally disabled from a pulmonary standpoint, but that disability was due to cigarette smoking.

In his deposition, Dr. Fino again articulated the reasoning behind his conclusions contained within his report. (EX 3). He did state, however, that he considered the fact that both cigarette smoking and coal dust exposure could have contributed to Claimant's current impairment, but that the objective evidence indicates that it is entirely cigarette smoking induced.

Treatment Records

Contained at DX 16 are treatment records from the Stone Mountain Health Services – St. Charles Respiratory Clinic dated from April 29, 2002 through October 20, 2003. The records include the following:

- x-ray report from a film dated April 29, 2002 by Dr. Alexander
- x-ray report from a film dated March 26, 2003 by Dr. Aycoth
- PFT dated May 13, 2002 by Dr. Narayanan
- PFT dated April 30, 2003 by Dr. Narayanan
- Two pages of office notes by Kelly Brooks, a family nurse practitioner. Ms. Brooks notes he is seen by Dr. Alam once every month. Claimant complained of increase in shortness of breath and had a "brushing and washings of his lungs" in May 2003. Claimant also states he has a daily cough with sputum production, and produces as much as a cup of sputum at night. According to Claimant, this cough has existed since 1975. Shortness of breath occurs after walking approximately 25-30 feet. She assesses coal workers' pneumoconiosis and COPD.

Smoking History

At the hearing, Claimant indicated that he still smoked, but had recently cut down to half a pack a day for the last three or four years. (Tr. 22). He also indicated that he had smoked for about twenty-five to twenty-six years all together. (Tr. 23). Dr. Baker considered a smoking history beginning 25-30 years ago at a pack a day in the past, and currently at half a pack a day. Dr. Dahhan considered a smoking history of thirty years, with a pack per day until eight years ago when Claimant cut down to half a pack days. Dr. Alam considered a variety of smoking histories. In January of 2004, he considered a prior history of tobacco abuse down to "only smoking maybe one or two cigarettes a day," but later stated in the same report Claimant "completely quit smoking." In February of 2006, Dr. Alam noted Claimant has not smoked in the last six months, since the stents were placed in his heart. Dr. Fino noted that Claimant had a thirty-pack year smoking history, beginning in 1974 with recently cutting down to half a pack days. In examining the record, it is clear that Claimant tends to underestimate his smoking history based upon whom he is talking to. As such, after weighing all the testimony and medical evidence, I find that Claimant smoked thirty pack years and continued to smoke half a pack a day at the time of the hearing.

DISCUSSION AND APPLICABLE LAW

Claimant's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section;

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202);

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203);

   (iii) Is totally disabled (see § 718.204(c));

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island*

Creek Coal Compamy, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the material change in conditions language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
>
> (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

§ 725.309(d) (April 1, 2002).

Claimant's prior claim was denied after it was determined that he failed to establish any of the elements of entitlement. (DX 1). Consequently, the Claimant must establish, by a preponderance of the newly submitted evidence, at least one applicable condition of entitlement previously adjudicated against him.

Total Disability

Claimant may establish a material change in conditions by demonstrating that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under § 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

There is no evidence of complicated pneumoconiosis in the record. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. Also, in *Crappe v. U.S. Steel Corp*., 6 B.L.R. 1-476 (1983), the Board held that a non-conforming PFT may be entitled to probative value where the study was not accompanied by statements of miner cooperation and comprehension and the ventilatory capacity was above the table values. This is because any deficiency in cooperation and comprehension could only result in higher results.

The first PFT contained in the record was conducted on May 13, 2002 and did not produce qualifying values. The second PFT conducted on April 30, 2003 did not produce qualifying values.[25] The third PFT conducted on May 9, 2003 produced qualifying results pre, but not post bronchodilator. The fourth PFT conducted on June 6, 2003 produced qualifying values.[26] The final PFT of record was administered on June 10, 2004. The results produced qualifying values both pre and post bronchodilator. Here, there are four qualifying tests and only three non-qualifying tests. However, the pattern of the PFT tests shows a worsening disability and presents a digression of Claimant's pulmonary capacity. As such, I place more weight on the recent PFTs. Thus, I find that Claimant has established total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of ABGs meet the requirements listed in the tables found at Appendix C to Part 718. None of the ABGs of record produced qualifying values. I therefore find that Claimant has not established the existence of total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with

[25] In the first two PFTs – bronchodilators were not administered.
[26] No bronchodilators were administered.

right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant last worked as a foreman, which required him to pick rock, shovel rock and coal, lift ties, drop cars, drop loads, and run a loader while overseeing the work of others. (Tr. 13-14; 16). The weight of lifting ties could get up to 300 pounds and take two men. (Tr. 14). Claimant constantly wore a mining belt, weighing ten to fifteen pounds. (Tr. 15). This continued until Claimant left the coal mining industry in 1986.

Drs. Fino, Alam, and Dahhan all opined that Claimant was totally disabled from a pulmonary standpoint based on an accurate employment history, objective tests, and a physical examination (in some cases, more than one examination). Each physician described in great detail how the objective tests in conjunction with their physical examinations revealed an individual who no longer possessed the pulmonary capacity to return to his former coal mine employment. As each physician relied upon objective evidence and their respective examinations to articulate their conclusions, I find their opinions well-reasoned and well-documented.

No medical opinion of record contradicts the above three physicians on the issue of total disability. Ms. Brooks describes an individual who can barely walk without shortness of breath – much less perform the work of a coal miner. Dr. Baker describes Claimant's impairment moderate – but makes no finding on the issue of total disability (i.e., whether miner is either totally disabled from a pulmonary standpoint or has the pulmonary capacity to return to his former coal mine employment). As Dr. Baker made no finding on total disability, I find his opinion to be neither well-reasoned nor well documented on this issue. As such, I accord it no weight.

As no opinions exist to contradict Drs. Fino, Alam, and Dahhan, the medical narrative evidence supports a finding of total pulmonary disability. Thus, I find that Claimant has established total pulmonary disability under § 718.204(b)(iv).

Reviewing the evidence considered under § 718.204(b) as a whole, I find that Claimant has established that he is totally disabled due to a respiratory or pulmonary impairment under subsection (b)(2)(i) and b(2)(iv). Since the newly submitted evidentiary record establishes total disability, and this evidence differs "qualitatively" from the evidence previously submitted, Claimant's subsequent claim will not be denied on the basis of the prior denial. As a result, I will consider the entire record *de novo* to determine ultimate entitlement to benefits.

PRIOR MEDICAL EVIDENCE[27]

X-RAYS

Exhibit	Date of X-Ray	Date of Reading	Physician/Qualification	Interpretation
DX 1	09/16/1997	09/16/1997	Wicker/B-reader	Negative
DX 1	09/16/1997	10/04/1997	Sargent/B-reader, BCR	Negative
DX 1	09/16/1997	05/28/1998	Wiot/B-reader, BCR	Negative
DX 1	09/16/1997	06/09/1998	Shipley/B-reader, BCR	Negative
DX 1	09/16/1997	06/19/1998	Spitz/B-reader, BCR	Negative
DX 1	09/16/1997	07/29/1998	Duncan/B-reader, BCR	Negative
DX 1	09/16/1997	07/31/1998	Soble/B-reader, BCR	Negative
DX 1	09/16/1997	08/13/1998	Laucks/B-reader, BCR	Negative
DX 1	10/16/1997	10/16/1997	Reddy	1/1
DX 1	10/16/1997	05/30/1998	Sargent/B-reader, BCR	Negative
DX 1	10/16/1997	07/29/1998	Duncan/B-reader, BCR	Negative
DX 1	10/16/1997	07/31/1998	Soble/B-reader, BCR	Negative
DX 1	10/16/1997	08/13/1998	Laucks/B-reader, BCR	Negative
DX 1	10/16/1997	10/22/1998	Cappiello/B-reader, BCR	1/1
DX 1	10/16/1997	10/30/1998	Ahmed/B-reader, BCR	0/1
DX 1	06/15/1998	06/15/1998	West/B-reader, BCR	Negative
DX 1	06/15/1998	06/22/1998	Halbert/B-reader, BCR	Negative
DX 1	06/15/1998	06/30/1998	Poulos/B-reader, BCR	Negative
DX 1	06/15/1998	07/19/1998	Wiot/B-reader, BCR	Negative
DX 1	06/15/1998	07/29/1998	Spitz/B-reader, BCR	Negative
DX 1	06/15/1998	08/16/1998	Shipley/B-reader, BCR	Negative
DX 1	06/15/1998	09/03/1998	Westerfield/B-reader	Negative
DX 1	07/15/1998	07/15/1998	Jarboe/B-reader	Negative
DX 1	07/15/1998	07/20/1998	Miller	COPD

PULMONARY FUNCTION TESTS

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height[28]	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results	Comments
DX 1	Yes	58/65.5	1.70	2.41		70	No	"effort was poor at best"
9/16/1997	Good/Good							

[27] The evidence from Judge O'Neill's 1993 denial, due to its age, is of little probative value and will be given no weight due to its remoteness. All other evidence summarized in his denial is incorporated herein by reference. The evidence contained in Judge Jansen's 2001 denial is more recent and therefore more probative. Therefore, it shall be re-outlined in this opinion.

[28] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). As three of the four tests show Claimant's height to be 65.5 inches, I will use the most common finding and find the Miner's height to be 65.5 inches for purposes of these tests.

DX 1	Yes	58/65.5	2.18	3.34	99	65	No	Submaximal effort
10/08/1997	Good/Good							
DX 1	Yes	58/65.5	2.17	3.67	95	59	No	FEV1 not reproducible
07/15/1998	Good/Good		2.65*	4.25*	107*	62*	No*	
DX 1	Yes	59/65	1.70	2.41		70	No	
09/30/1998	Good/Good							

* Indicates Post-Bronchodilator Values

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**	**Comments**
DX 1	10/16/1997	31.9	93.2	No	
DX 1	07/15/1998	36	81.5	No	

Narrative Reports

Dr. Jarboe examined Claimant on July 16, 1998 and provided a medical report. (DX 1). Claimant indicated he had only smoked half a pack a day for approximately eight to nine years.[29] Dr. Jarboe, however, noted his carboxyhemoglobin level indicated Claimant smoked a pack a day. Dr. Jarboe indicated a twenty-six year coal mining history. Based upon x-rays, PFTs, an ABG study, and physical examination, Dr. Jarboe opined Claimant did not suffer from pneumoconiosis. He believed Claimant suffered from asthma, and had a moderate obstructive defect which not totally disabling. In his deposition, Dr. Jarboe noted Claimant's obstructive defect was reversible to a mild impairment and that the radiographic evidence was negative for pneumoconiosis.

Dr. Sundram examined Claimant on April 16, 1998 and provided a medical report. (DX 1). Furthermore, it is noted that Dr. Sundram was Claimant's treating physician, as over nine years of office notes are provided in the record. (DX 1). All of the notes diagnose Claimant with COPD and coal workers' pneumoconiosis – along with periodic bronchitis. However, concerning the April 16, 1998 examination and report, Dr. Sundram stated he based his diagnosis upon x-rays, PFTs, and social histories. This included a half a pack day smoking habit, with an unknown duration. Dr. Sundram's ultimate diagnosis echoed his treatment notes and diagnosed Claimant with COPD and coal workers' pneumoconioiss. No etiological determination of Claimant's total disability is given.

Dr. Wicker examined Claimant on September 16, 1997 and provided a medical report. (DX 1). Dr. Wicker reviewed x-rays, PFTs, ABGs, and an EKG. He considered twenty-five

[29] This is drastically inconsistent with what Claimant told other physicians.

years of coal mine employment and a twenty pack year smoking history. Based upon the objective evidence and his physical examination, he determined that Claimant did not suffer from coal workers' pneumoconiosis.[30]

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

§§ 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

[30] It should be noted that Dr. Wicker considered the PFT study invalid due to what he considered an extremely poor effort.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the readers' qualifications. *Goss v. Eastern Associated Coal Co.*, 7 B.L.R. 1-400 (1984); *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985) (granting great weight to a B-reader); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985) (granting even greater weight to a Board-certified radiologist).

Additionally, the Board has held that it is within the discretion of the administrative law judge to defer to the numerical superiority of the x-ray interpretations. *Edmiston v. F & R Coal Co.*, 14 B.L.R. 1-65 (1990). The United States Court of Appeals for the Sixth Circuit has confirmed that consideration of the numerical superiority of the x-ray interpretations, when examined in conjunction with the readers' qualifications, is a proper method of weighing x-ray evidence. *Stanton v. Norfolk & Western Railway Co.*, 65 F.3d 55 (6th Cir. 1995) (citing *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993)).

The record contains four newly submitted chest x-rays and four older chest x-rays.[31] I shall address the older x-rays first.

The first x-ray dated September 16, 1997 was interpreted negative by Drs. Wicker, Sargent, Wiot, Shipley, Spitz, Duncan, Soble, and Laucks. There are no contrary readings. Thus, I find the September 16, 1997 film to be negative for pneumoconiosis.

The second x-ray, which is dated October 16, 1997 was interpreted to be positive by Drs. Reddy and Cappiello. The record is void of any qualifications Dr. Reddy may hold – so I consider him to have none. Dr. Cappiello is both a B-reader and BCR certified. However, the same x-ray was read to be negative by Drs. Sargent, Duncan, Soble, Laucks, and Ahmed. All of these physicians are dually qualified. As such, I find this x-ray to be negative.

The third x-ray dated June 15, 1998 was read to be negative by Drs. West, Halbert, Poulos, Wiot, Spitz, Shipley, and Westerfield. There are no contrary interpretations. As such, I find this x-ray to be negative.

The fourth x-ray dated July 15, 1998 was read by Dr. Jarboe, a B-reader, to be negative. Dr. Miller, who appears to hold no qualifications, read this x-ray as showing "COPD," and provided no etiology to link this interpretation to a reading of legal pneumoconiosis. As such, given Dr. Jarboe's qualifications and direct reading, I find this x-ray to be negative.

Considering the new x-ray evidence, the first x-ray dated April 29, 2002 was found to be positive by Dr. Alexander who is a dually qualified reader. Dr. Wheeler, who holds equal qualifications, read this film to be negative and a category three quality. In rebuttal, Dr. Alexander stated it appears Dr. Wheeler read a copy of the x-ray (which he noted was dark, as Dr. Wheeler described it when giving it a "3" quality), rather than the original. However, Dr.

[31] The x-rays in the first claim are all over ten years old. As such, I find them to have little value in determining Claimant's present condition and accord them no weight.

Alexander cannot be *certain* that Dr. Wheeler read a copy of the x-ray and not the original. Therefore, I will defer to Dr. Wheeler's reading – and give weight to his interpretation. Therefore as both physicians are dually qualified readers and come to different conclusions – I find this x-ray to be inconclusive to determine the existence of pneumoconiosis.

The second x-ray dated March 26, 2003 was read to be positive by Dr. Aycoth, who is a B-reader. Dr. Wheeler, who is a dually qualified reader, read the same x-ray to be negative. Given Dr. Wheeler's superior credentials, I defer to his interpretation of the x-ray and find it to be negative.

The third x-ray dated May 5, 2003 was read to be positive by Dr. Ahmed, who is a dually qualified reader. Dr. Baker, who is a B-reader, read this film to be negative. Given Dr. Ahmed's superior credentials, I defer to his interpretation of the x-ray and find it to be positive for pneumoconiosis.

The fourth and most recent x-ray was read to be positive by Dr. Ahmed, who is a dually qualified reader. Dr. Dahhan, who holds B-reader credentials, found this film to be negative for pneumoconiosis. Given Dr. Ahmed's superior credentials, I defer to his interpretation of the x-ray and find it to be positive for pneumoconiosis.

Here, I have found all four of the x-rays from the earlier claim to be negative. In the more recent claim, I have found two of the x-rays to be positive, one of them to be negative, and one to be inconclusive. I recognize that, the basic premise underlying 20 C.F.R. §725.309 (2004) is that pneumoconiosis is a progressive and irreversible disease. § 718.201(c). *See also Mullins Coal Co. of Virginia v. Director, OWCP*, 483 U.S. 135 (1987), *reh'g. denied*, 484 U.S. 1047 (1988) (where the Supreme Court stated that pneumoconiosis is a "serious and progressive pulmonary condition."); *and see Peabody Coal Co. v. Odom*, 342 F.3d 486 (6th Cir. 2003) (pneumoconiosis is a progressive and latent disease which "can arise and progress even in the absence of continued exposure to coal dust"). As pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-;Robbins Coal Co*., 12 B.L.R. 1-;149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-;131 (1986); § 718.201(c). However, in this instance – there is not a great deal of time separating the newer x-rays from the older ones. Here, the older x-rays have twenty negative readings, most of which are given by dually qualified readers. As only a few years come between the more recent readings and the numerous older readings, I find the newer evidence does not outweigh the old. Thus, I find that the preponderance of the chest x-ray evidence does not establish the existence of pneumoconiosis. Therefore, I find that Claimant has not established the presence of pneumoconiosis under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director*, OWCP, 7 B.L.R. 1-860 (1985). First, I shall address the opinions from the previous claim.

Dr. Sundaram diagnosed clinical pneumoconiosis based upon his physical examination as well as an x-ray. However, the x-ray he determined to be positive was in fact read negative by others more qualified than him. Furthermore, Dr. Sundaram stated in his medical opinion that he did not have a length of smoking history, nor did he describe the amount of coal dust to which Claimant may have been exposed. A report may be given little weight where it is internally inconsistent and inadequately reasoned. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986). *See also Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.). As Dr. Sundaram failed to have a complete picture of Claimant's smoking and employment history, and the x-ray he relied upon was in fact found to be negative, I find his opinion to be neither well-reasoned nor well-documented. Thus, it is accorded little weight.

In opining that Claimant did not suffer from pneumoconiosis (either clinical or legal), Dr. Wicker failed to point to any objective evidence which he may have relied on in coming to a diagnosis. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal*

Co., 10 B.L.R. 1-19 (1987). Here, Dr. Wicker failed to provide adequate documentation to support his conclusions. As such, I find his opinion to be neither well-reasoned nor well-documented. Thus, I accord it little weight.

Dr. Jarboe opined in his 1998 report that Claimant did not suffer from any form of pneumoconiosis. In doing so, he noted a correct work history and suspected Claimant was not telling the truth about his smoking history.[32] In forming his opinion, Dr. Jarboe articulated his reliance on the objective studies, as well as his physical examination. Given Dr. Jarboe's superior credentials as an internist and pulmonologist, I accord his opinion probative weight.

Regarding the newer evidence of record, Dr. Baker opined in his May 5, 2003 report that Claimant did not suffer from clinical pneumoconiosis, but did in fact suffer from legal pneumoconiosis. Regarding clinical pneumoconiosis, Dr. Baker relied upon a negative x-ray, a physical examination, a lengthy medical history, ABGs, and PFTs.[33] Since he relied upon objective data and clearly articulated his opinion, I find his conclusions regarding clinical pneumoconiosis to be well-reasoned and well-documented. Thus, I accord his opinion probative weight.

Concerning legal pneumoconiosis, Dr. Baker diagnosed COPD with moderate obstructive defect based on the non-reproducible PFT and chronic bronchitis based on a history of cough, sputum production, and wheezing. First, the PFT Dr. Baker relies on to diagnose the COPD was found to be invalid by Dr. Burki. (DX 13). Dr. Baker also diagnoses chronic bronchitis based solely upon the history provided to him by the Claimant. Neither of these sources is adequate to support a well-reasoned opinion. As such, I find his diagnosis of legal pneumoconiosis to be neither well-reasoned nor well-documented and accord it little weight.

Dr. Dahhan opined that Claimant suffered from neither legal nor clinical pneumoconiosis. In his report dated May 9, 2003, Dr. Dahhan stated that the objective evidence, including the x-ray, PFT, ABG along with his physical examination revealed that Claimant did not suffer from either clinical or legal pneumoconiosis. Specifically, Dr. Dahhan pointed to the negative x-ray along with the significant response to bronchodilator response in the PFT. This, according to Dr. Dahhan, shows an obstructive impairment which is not the result of coal dust exposure, but rather years of smoking. Furthermore, in his deposition, Dr. Dahhan emphasizes how the x-ray he viewed showed hyperinflated lungs – a sign of emphysema caused by smoking. He again stated that his findings were based upon "the entire data including the clinical examination, the pulmonary function studies, before and after bronchodilators, and arterial blood gases and a chest x-ray." (EX 1). Given that Dr. Dahhan had a correct employment and smoking history, and that he relied upon objective evidence with which to draw his conclusions, I find his opinion to be well-reasoned and well-documented. Thus, given his advanced credentials, it is accorded probative weight.

[32] He based this opinion on the carboxyhemoglobin present in the ABG. The evidence of record supports his conclusions in this regard.

[33] Even though the PFTs were invalid, Dr. Baker did not rely heavily on them for his diagnosis. Therefore, I find the fact they were invalid to not affect the weight his opinion should be given.

Dr. Alam provided two medical reports. At the time the first report was written in 2004, Dr. Alam had been treating Claimant for about a year. The next report was written two years later in 2006. In the first report, Dr. Alam concluded that Claimant suffered from clinical and legal pneumoconiosis. Regarding clinical pneumoconiosis, Dr. Alam relied upon a chest x-ray which showed "bil (sic)[bilateral?] interstitial changes compatible with stage one of clinical pneumoconiosis." However Dr. Alam fails to identify specifically which x-ray he relied upon. Thus, I have no way of determining if this x-ray is in the record. In *Keener v. Peerless Eagle Coal Co.*, the Board emphasized that a medical opinion must be based on evidence that is "properly admitted" in a claim. *Keener v. Peerless Eagle Coal Co.*, ___ B.L.R. ___, BRB No. 05-1008 BLA (Jan. 26, 2007)(en banc). If a report is based on evidence not admitted in the claim, then the administrative law judge must "address the impact of Section 725.414(a)(2)(i), (a)(3)(i)." *Id.* The Board noted that the Administrative Law Judge has several options in handling a report based, in part or in whole, on evidence not admitted in the claim such as excluding the report, redacting the objectionable content, asking the physician to submit a new report, or "factoring in the physician's reliance upon the inadmissible evidence when deciding the weight to which his opinion is entitled." *Id.* The Board specifically stated, however, that "exclusion is not a favored option, because it may result in the loss of probative evidence developed in compliance with the evidentiary limitations." *Id.*

Here, Dr. Alam did not rely solely upon the x-ray for his clinical pneumoconiosis finding. He also relied upon numerous physical examinations. However, the smoking history Dr. Alam listed is ambiguous at best. Dr. Alam provided no length of smoking history – and stated Claimant was down to one or two cigarettes a day (later, in the same report, he stated Claimant no longer smoked). A report may be given little weight where it is internally inconsistent and inadequately reasoned. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986). *See also Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.). Here, Dr. Alam relied upon an inaccurate history and an x-ray that is not in the record. As such, his diagnosis of clinical pneumoconiosis is neither well-reasoned nor well documented. Because of its numerous deficiencies, I accord it no weight. [34]

Dr. Alam's second report dated February 14, 2006 also cites an x-ray to support his position. This time he stated the x-ray showed "significant emphysema bilaterally with nodular densities." However, he again failed to articulate which specific x-ray he relied upon and whether it is included in the record. Dr. Alam opined that "[i]t is the progression of his coal workers' pneumoconiosis causing him to have worsening lung function although he does have history of tobacco abuse, but he quit six months ago." However, at the hearing, Claimant testified that he was in fact still smoking.[35] Because Dr. Alam relied on an absence of smoking history to account for the continued decline of Claimant's pulmonary condition – when this was in fact not the case, and an x-ray which may or may not be in the record, I find his opinion

[34] All of this is despite Dr. Alam's status as a treating physician and his advanced credentials as an internist and pulmonologist.

[35] The hearing took place approximately five months after this report was written.

regarding legal and clinical pneumoconiosis to be neither well-reasoned nor well documented. Because of its numerous deficiencies, I accord it no weight.[36]

After examining Claimant on June 10, 2004 and conducting an extensive medical evidence review, Dr. Fino opined that Claimant suffered from neither clinical nor legal pneumoconiosis. Dr. Fino considered both a correct employment and smoking history. After listing Claimant's symptoms, current medications, and past medical history, Dr. Fino pointed to the objective testing he conducted, (x-ray, PFT, ABG) as well as his physical examination and the other medical evidence which led him to his conclusion. Dr. Fino articulated how the objective evidence lead him to conclude Claimant's impairment is entirely smoking induced, and not aggravated or caused in any way by exposure to coal dust.[37] Specifically, Dr. Fino noted that the improvement following bronchodilators was consistent with a smoking-related condition, and that had coal dust been a factor, the impairment would be much more severe. Dr. Fino also pointed to the PFT and how it has decreased over time which showed "that his progressive decline in FEV1 over the years is related to cigarette smoking and that is the cause of this man's disability." This was all in conjunction with a radiographic image. As Dr. Fino clearly articulated his opinion and how it was backed by the objective evidence he considered, I find his opinion to be well reasoned and well documented. Thus, given his advanced credentials as an internist and pulmonologist, and the fact he had a complete view of Claimant's history, I accord his opinion substantial probative weight.

Kelly Brooks, a nurse practitioner, wrote an office note in which she assessed coal workers' pneumoconiosis. This was based upon a personal history, and a physical examination. No objective testing is noted in her notes. As Ms. Brooks did not rely upon objective testing, and is not a licensed physician, I place little weight on her assessment.

Here, I have found no opinions well-reasoned or well-documented that diagnose either legal or clinical pneumoconiosis. However, the opinions of Drs. Dahhan and Fino have received probative and substantial probative weight, respectively. Both of them concluded, based upon objective evidence, that Claimant did not suffer from coal workers' pneumoconiosis or legal pneumoconiosis. As their opinions are well-reasoned, I am more persuaded by their findings. Therefore, I find that the Claimant has failed to establish the presence of pneumoconiosis by a preponderance of the evidence under subsection (a)(4).

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[36] The parties may feel as though it is unfair to discredit a physician's opinion where he relies upon evidence outside the scope of § 725.414, especially since attorneys may not decide what evidence to designate for submission until the hearing. However, in *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006)(en banc)(J. McGranery and J. Hall, concurring and dissenting), the Board held that a physician's medical opinion must be based on evidence that is admitted into the record in accordance with 20 C.F.R. § 725.414. In articulating its reasoning, the Board stated that "[w]ithin this new regulatory framework, requiring an administrative law judge to fully credit an expert opinion based upon inadmissible evidence could allow the parties to evade both the letter and the spirit of the new regulations by submitting medical reports in which the physicians have reviewed evidence in excess of the evidentiary limitations."

[37] Dr. Fino acknowledged that two risk factors which could cause Claimant's condition were coal dust exposure and smoking.

Claimant has not established the presence of pneumoconiosis under subsections (a)(1)-(4). Therefore, I find that Claimant has not established pneumoconiosis under § 718.202(a).

Causation of Pneumoconiosis

Once pneumoconiosis has been established, the burden is upon the Claimant to demonstrate by a preponderance of the evidence that the pneumoconiosis arose out of the miner's coal mine employment. 20 C.F.R. § 718.203 (2003).

If a miner suffers from pneumoconiosis and was employed ten years or more in the Nation's coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b); *Stark v. Director,* OWCP, 9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.*, 9 B.L.R. 1-137 (1986). If I had found that Claimant suffered from pneumoconiosis, he would be entitled to the rebuttable presumption set forth in § 718.203(b) that his pneumoconiosis arose out of his coal mine employment. However, I have found Claimant has not established the existence of pneumoconiosis. Therefore, he is not entitled to the reubuttable presumption under § 718.203(b), and I find there is no causation.

Total Disability Due to Pneumoconiosis

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a prima facie finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to section 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. Section 718.204(a); *Jewell Smokeless Coal Corp. v. Street,* 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

While Claimant has established the existence of a totally disabling pulmonary impairment, he has not established the existence of pneumoconiosis. Therefore, he cannot be totally disabled by a disease which he has not established.

Entitlement

Claimant established a material change in conditions sufficient to meet the statutory requirements of § 725.309(d), but he failed to prove that he suffers from pneumoconiosis or that he is totally disabled due to pneumoconiosis. Therefore, Claimant is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of E.K. for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013- 7601. *See* 20 C.F.R. §§ 725.478 and 725.479. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).